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The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline

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Summary

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148). Among its provisions, the ACA reenacts, amends, and permanently reauthorizes the Indian Health Care Improvement Act (IHCIA). IHCIA authorizes many specific Indian Health Service (IHS) activities, sets out the national policy for health services administered to Indians, and sets health condition goals for the IHS service population to reduce "the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians." The reauthorization of IHCIA in the ACA amends the IHCIA to, among other changes, expand programs that seek to augment the IHS health care workforce, increase the amount and type of services available at facilities funded by the IHS, and increase the number and type of programs that provide behavioral health and substance abuse treatment to American Indians and Alaska Natives.

This report provides a brief overview of IHCIA and summarizes the provisions of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 as enacted and amended by Section 10221 of the ACA. **Appendix A** presents a timeline of the deadlines included in the act. Another report, CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler, more briefly summarizes the major changes made by the ACA to IHCIA and includes a discussion of other provisions in the ACA that may affect IHS and American Indian and Alaska Native health and their access to health care.

This report is primarily for reference purposes. The material in it is intended to provide context to help the reader better understand the intent of ACA's individual provisions at the time of enactment. The report does not track or discuss ongoing ACA-related regulatory and other implementation activities.

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Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148).[1] Among its provisions, the ACA creates a mandate for most U.S. residents to obtain health insurance and provides for the establishment of insurance exchanges through which certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing that coverage. The new law expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in Medicare spending that had been projected under preexisting law; imposes an excise tax on insurance plans determined to have high premiums; and makes other changes to the federal tax code, Medicare, Medicaid, and numerous other programs.[2] The ACA also reenacts, amends, and permanently reauthorizes the Indian Health Care Improvement Act (IHCIA).[3] Specifically, Section 10221(a) of the ACA enacted the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790)[4] (hereinafter referred to as the IHCIA Reauthorization and Extension Act). Section 10221(b) of the ACA amended sections of the IHCIA Reauthorization and Extension Act (e.g., Sections 111, 134, and 201) and amended one section of IHCIA not included in the IHCIA Reauthorization and Extension Act (Section 806). Another report, CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler, more briefly summarizes the major changes made by the ACA to IHCIA and includes a discussion of other provisions in the ACA that may affect the Indian Health Service (IHS), American Indian and Alaska Native health, and their access to health care.

IHCIA authorizes many specific IHS activities, sets out the national policy for health services administered to Indians, and sets health condition goals for the IHS service population to reduce "the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians."[5] Prior to the ACA, IHCIA was last fully reauthorized by the Indian Health Amendments of 1992,[6] which extended authorizations of its appropriations through FY2000. The authorizations for all IHCIA programs were later extended through FY2001.[7] Although authority

[1] The ACA was subsequently amended by the Health Care and Education Reconciliation Act (HCERA, P.L. 111-152) and has since been amended by other laws. In this report, the ACA refers to the ACA as amended.

[2] CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead. On June 28, 2011, the Supreme Court ruled, in National Federation of Independent Business v. Sebelius (NFIB), on the constitutionality of both the ACA-implemented individual mandate, which requires most U.S. residents (beginning in 2014) to carry health insurance or pay a penalty, and the ACA Medicaid expansion. The Court upheld the individual mandate as a constitutional exercise of Congress's authority to levy taxes. The penalty is to be paid by taxpayers when they file their tax returns and enforced by the Internal Revenue Service. In a separate opinion, the Court found that compelling states to participate in the ACA Medicaid expansion—which the Court determined to be essentially a new program—or risk losing their existing federal Medicaid matching funds was coercive and unconstitutional under the Spending Clause of the Constitution and the Tenth Amendment. The Court's remedy for this constitutional violation was to prohibit HHS from penalizing states that choose not to participate in the expansion by withholding any federal matching funds for their existing Medicaid program. However, if a state accepts the new ACA expansion funds (initially a 100% federal match), it must abide by all the expansion coverage rules. Under NFIB, all other provisions of ACA—including the Indian Health Care Improvement Act—remain fully intact and operative.

[3] P.L. 94-437, act of September 30, 1976, 90 Stat. 1400, as amended; 25 U.S.C. §1601 et seq., and 42 U.S.C. §1395qq, 1396j (and amending other sections). CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead.

[4] As reported by the Senate Committee on Indian Affairs on December 16, 2009.

[5] See "Section 102. Findings" below.

[6] P.L. 102-573, act of October 29, 1992, 106 Stat. 4526. Previous reauthorizations occurred in 1980 (P.L. 96-537) and 1988 (P.L. 100-713), and substantial amendments were made in 1990 (P.L. 101-630, Title V).

[7] Omnibus Indian Advancement Act, P.L. 106-568, §815, act of December 27, 2000, 114 Stat. 2868, 2918.

had expired, IHCIA authorized programs continued to receive annual appropriations since FY2001.

Overview of Indian Health Care[8]

The IHS, an agency within the Department of Health and Human Services (HHS), provides health care for approximately 2.2 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[9] IHS provides services in 35 states, subdivided into 12 geographic "Areas" that consist of one or more states.[10] Each Area is administered by an Area Office; Areas, in turn, are further subdivided into service units that consist of one or more facilities. IHS may provide services directly, or Indian tribes (ITs) or tribal organizations (TOs) may operate IHS facilities and programs themselves through self-determination contracts and self-governance compacts negotiated with IHS.[11] Although most IHS facilities are located on or near reservations, IHS also funds urban Indian health projects (UIHPs), through grants or contracts to urban Indian organizations (UIOs).

The IHCIA authorizes many specific IHS activities, sets out the national policy for health services administered to Indians, and declares that one of the federal goals for the health condition of the IHS service population is to "provide the quantity and quality of health services that will permit the health status of Indians to be raised to the highest possible level."[12] Significantly, IHCIA authorizes direct collections from Medicare, Medicaid, and other third-party insurers. IHCIA also gave IHS authority to grant funding to UIOs, authorized programs to expand the health care workforce providing services at IHS-funded facilities, and authorized programs that address health concerns for the American Indian and Alaska Native population (e.g., substance abuse, suicide, diabetes).

Overview of Report

This report summarizes the provisions of the IHCIA Reauthorization and Extension Act as enacted by Section 10221 of the ACA.[13] This report is primarily for reference purposes. The material in it is intended to provide context to help the reader understand the intent of the ACA's individual provisions at the time of enactment. The act includes two titles. Title I contains amendments to the eight IHCIA titles. Title II amends and reauthorizes the Native Hawaiian Health Care Act,[14] which authorizes health education, health promotion, disease prevention services, and health professions scholarship programs for Native Hawaiians.[15] This report focuses

[8] For more detailed overview information on the Indian Health Service (IHS), see CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

[9] U.S. Department of Health and Human Services, Indian Health Service, IHS Fact Sheet: IHS Year 2013 Profile http://www.ihs.gov/newsroom/factsheets/ihsyear2013profile/.

[10] IHS provides services to American Indians and Alaska Natives residing in 35 states. Area offices may serve tribes in one state, such as the Alaska Area office that administers services in Alaska, or in multiple states, such as the Nashville area office that administers services for tribes on the east coast, in Alabama, Louisiana, and parts of Texas.

[11] Authorized by P.L. 93-638, the Indian Self-Determination and Education Assistance Act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

[12] See "Section 102. Findings" below.

[13] Although the ACA has amended by subsequent laws, Section 10221 has not been further amended.

[14] Sec. 201(a), P.L. 81-152, act of June 30, 1949, 63 Stat. 377, 383, as amended; 40 U.S.C. 501.

[15] This program receives appropriations through the federal health center program. For more information, see http://bphc.hrsa.gov/about/specialpopulations/index.html.

on Title I, which contains eight sections, each of which amends a specific IHCIA Title. Title I also, with some exceptions, consolidates IHCIA appropriations into a single section, repealing authorizations that had previously been included at the end of each of IHCIA's eight titles. The section numbers below refer to the section numbers in the IHCIA Reauthorization and Extension Act. Where appropriate, sections amended by Section 10221(b) of the ACA are noted. The subtitles below refer to those in the IHCIA Reauthorization and Extension Act, which correspond to the IHCIA title they amend. Each subtitle begins with some background on the IHCIA title it amends to provide context for the descriptions of the law's provisions. This background reflects the policy issues at the time of enactment and does not reflect the effects of the ACA. **Table 1** describes the major differences between the IHCIA and the IHCIA Reauthorization Extension Act.

Table 1. IHCIA Reauthorization Summary

IHCIA Title Name and Subject	ACA
Title I-Indian Health Manpower Authorizes workforce programs to increase the supply of providers at IHS facilities	Maintains title's major sections; repeals section authorizing appropriations for the title; expands use of community health aide workers at IHS-funded facilities; adds a new section funding a demonstration to address IHS health professional shortages; and exempts employees at IHS-funded facilities from certain licensing, registration requirements and related fees.
Title II-Health Services Authorizes IHS health services, research, payments for service-related transportation, payment for services provided through contracts with outside providers (i.e., Contract Health Services (CHS))	Maintains title's major sections; repeals section authorizing appropriations for the title; amends authorization for two funds (Indian Health Care Improvement Fund and Catastrophic Health Emergency Fund); expands IHS authority for diabetes, cancer screening, and long-term care programs; and amends sections related to the CHS program.
Title III-Health Facilities Authorizes construction and renovation of IHS facilities; sets procedures by which construction and renovation projects are selected	Maintains title's major sections; repeals section authorizing appropriations for the title; amends IHS construction priority system; and adds new sections requiring grants to build modular and mobile facilities.
Title IV-Access to Health Services Authorizes IHS programs to bill Medicare, Medicaid, and private insurance	Maintains title's major sections; repeals section authorizing appropriations for the title; adds the State Children's Health Insurance Program to programs that IHS is authorized to bill; adds new sections permitting ITs, TOs, and UIOS to purchase federal employee health and life insurance benefits for their employees; expands IHS collaboration with the Department of Veterans Affairs and the Department of Defense.
Title V-Health Services for Urban Indians Authorizes grants to UIOs for health projects to serve urban Indians	Maintains title's major sections; repeals section authorizing appropriations for the title; expands grant opportunities available to UIOs.
Title VI-Organization Improvements Establishes IHS's organizational position within HHS; the position of Director of IHS; and requires an automated management information system for IHS record-keeping	Maintains title's major sections; establishes that the IHS Director should report directly to the HHS Secretary; adds new sections requiring: (1) an Office of Direct Service Tribes; and (2) a plan to create a new Nevada Area Office.
Title VII-Behavioral Health Programs Authorizes programs related to behavioral health prevention and treatment	Replaces IHCIA Title VII with new language authorizing new comprehensive behavioral health and treatment programs. Includes a new subsection authorizing programs related to youth suicide prevention.

IHCIA Title Name and Subject	ACA
Title VIII-Miscellaneous Requires the IHS Director to submit a number of reports; establishes IHS eligibility for health services; and defines California Indians, amongst other provisions	Maintains title's major sections; repeals section authorizing appropriations for the title; adds new sections that, among other things, establish (1) a prescription drugs monitoring program; (2) an IHS Director of HIV/AIDS Prevention and Treatment; and (3) new requirements for the IHS budget requests to reflect inflation and changes in the IHS service population.

Source: CRS analysis of P.L. 94-437, as amended (IHCIA), and P.L. 111-148 (ACA).

Appendix A includes a detailed timeline of effective dates for the IHCIA Reauthorization and Extension Act provisions. **Appendix B** includes a list of acronyms used in this report. The term "Secretary," as used in this report, means the Secretary of HHS, unless otherwise indicated. The term "Indian" in this report refers to "Indian" as defined in IHCIA. Under this definition, an Indian is a person who is a member of a federally recognized tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established pursuant to the Alaska Native Claims Settlement Act.[16] The ACA also defined a number of new Indian-related terms. Two of the new terms most frequently used in this report are Indian Health Program and Tribal Health Program. "Indian Health Program" (IHP) is defined as (1) any health program administered by the IHS, (2) any Tribal Health Program, or (3) any Indian tribe or tribal organization to which the Secretary provides funding under the Buy Indian Act. "Tribal Health Program" (THP) is defined as any IT or TO operating any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA).[17]

Title I—IHCIA Reauthorization and Amendments

Reauthorization, Findings, and Definitions

Section 101. Reauthorization

This section amends **IHCIA Section 825** [25 U.S.C. §1680o] with new language that authorizes an appropriation of such sums as may be necessary to carry out IHCIA for FY2010 and each fiscal year thereafter to remain available until expended. The section also repeals separate authorizations of appropriations that had been included in each IHCIA title. In addition, it reauthorizes IHCIA indefinitely.

Section 102. Findings

This section amends **IHCIA Section 2** [25 U.S.C. §1601] by adding a new congressional finding that states that providing resources, processes, and structure to eradicate health disparities between Indians and the general population, and that raising Indian health to the highest level are major national goals.

[16] P.L. 92-203, act of December 18, 1971, 85 Stat. 688, as amended; 43 U.S.C. 1601 et seq.

[17] P.L. 93-638 as amended.

Section 103. Declaration of National Indian Health Policy

This section amends **IHCIA Section 3** [25 U.S.C. §1602] with new language that states that Congress declares that it is the policy of this nation, in fulfillment of special responsibilities and legal obligations to Indians to (1) ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy; (2) raise Indian and urban Indian health status to that set forth in the Healthy People 2010 or successor objectives; (3) ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities; (4) increase the proportion of all degrees in the health professions and allied and associated professions awarded to Indians so that the proportion of Indian health professionals is the same as the general population in each IHS area; (5) require all actions under this act to be carried out with active and meaningful consultation with ITs and TOs, and conference with UIOs to Indian self-determination; (6) ensure the United States and ITs work in a government-to-government relationship to ensure quality health care for all tribal members; and (7) fund IT and TO-operated programs and facilities at the same level as IHS-operated programs and facilities.

Section 104. Definitions

This section amends **IHCIA Section 4** [25 U.S.C. §1604] by renumbering certain subsections and paragraphs related to specified definitions. The section maintains 12 IHCIA definitions (Area office; fetal alcohol effects; health profession; Indians or Indian; Indian tribe; Secretary; service; service area; substance abuse; urban center; Urban Indian; Urban Indian Organization), amends definitions for 5 terms (disease prevention, fetal alcohol syndrome (FAS), health promotion, service unit, and tribal organization), and adds 12 new terms, for a total of 29 terms. The 12 new terms are "behavioral health," "California Indians," "community college," "contract health service," "Department," "Indian Health Program," "junior or community college," "reservation," "telehealth," "telemedicine," "tribal college or university," and "Tribal Health Program."

This report uses the following terms, as they are used in the IHCIA Reauthorization and Extension Act, to refer to different types of Indian facilities that are eligible for a given program: "Indian Health Program" (IHP), which is defined as any health program administered by the IHS or by an IT or TO under either the Indian Self-Determination and Education Assistance Act, as amended (ISDEAA),[18] or the Buy Indian Act;[19] and "Tribal Health Program" (THP), which is defined as any IT or TO operating a health program under ISDEAA. THPs are included within the term IHP.

Subtitle A—Indian Health Manpower[20]

Subtitle A includes sections that amend IHCIA Title I "Indian Health Manpower." This title includes provisions related to personnel recruitment, scholarships, and other educational programs that seek to augment the Indian health workforce. IHS had high vacancy rates in many

[18] P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. §450 et seq.

[19] 25 U.S.C. § 47

[20] Title V of the ACA (Health Care Workforce) authorizes a number of new programs to augment the health care workforce and amends a number of existing programs. In a number of cases ITs, TOs, and UIOs may be eligible for these programs. See CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Elayne J. Heisler.

of its health professions—25% for physicians, 15% for dentists, and 16% for nurses, for instance, as of January 2010.[21] These vacancy rates are higher than those of federally funded health centers in rural areas, facilities that also have a difficult time recruiting providers.[22] The purpose of IHCIA Title I is to increase the number, and also enhance the skills, of Indian and non-Indian health professionals and other health personnel in the IHS.

The ACA maintains a number of existing sections that authorize scholarships for preparatory and professional schools. It also authorizes new programs that may expand the workforce at IHS, IT, TO, and UIO facilities. Specifically, it authorizes programs that may expand the use of community health workers outside of Alaska, may increase the number of providers at facilities with severe shortages, and it amends licensing requirements for UIO providers to facilitate UIOs provider recruitment.

Section 111. Community Health Aide Program[23]

This section amends **IHCIA Section 119** [25 U.S.C. §1616l] with new language that requires the Secretary, under authority of the Snyder Act,[24] to develop and operate a Community Health Aide Program (CHAP) in Alaska, under which IHS is to train Alaska Natives to provide health care, health promotion, and disease prevention in rural Alaska Native villages. The section requires the Secretary to provide, in a specified manner, a high standard of training to community health aides; establish teleconferencing capacity in health clinics located in or near those villages for use of CHAPs or community health practitioners; establish and maintain a CHAP certification board; and provide continuing education, close supervision, and a system to review and evaluate CHAP work. The section also prohibits a CHAP dental health aide therapist from performing certain pulpal therapy or extractions without a determination of a medical emergency by a licensed dentist and from performing any other oral or jaw surgeries except for uncomplicated extractions.

The section requires the Secretary, acting through IHS, to establish a neutral review panel to study the CHAP dental health aide therapist program to ensure that the quality of care is adequate and appropriate. The section specifies panel membership, the factors of the study, and requires consultation with Alaska tribal organizations, and a report to Congress.

The section also authorizes the expansion of CHAP, except for the dental health aide therapist program, into a national program, but requires that the expansion not reduce Alaska CHAP funding. The section exempts ITs and TOs using dental health aides from certain specified instructional requirements for ITs or TOs located in states (other than Alaska) that permit, under state law, dental health aide therapists or midlevel health providers to supply such services. The section requires the Secretary, acting through the IHS, to facilitate the implementation of dental health aide programs by ITs and TOs who elect to provide these services; and prohibits the Secretary from filling IHS program vacancies for certified dentists with dental health aides. The section further specifies that nothing in this section restricts the ability of IHS, an IT, or a TO to participate in any program or to provide any service authorized in any other federal law.

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[21] U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheets: Workforce," January 2010, http://www.ihs.gov/PublicAffairs/IHSBrochure/Workforce.asp.

[22] U.S. Department of Health and Human Services, Indian Health Service, *Indian Health Service: Fiscal Year 2012 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS, 2012), http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/FY%202012%20Budget%20Justification.pdf; hereinafter, IHS FY2012 Budget Justification.

[23] The text below reflects the amendments that ACA Sec. 10221(b)(1) made to this section.

[24] P.L. 67-85, 42 Stat. 208, as amended; 25 U.S.C. §13.

Section 112. Health Professional Chronic Shortage Demonstration Programs

This section adds a new **IHCIA Section 123** *Health Professional Chronic Shortage Demonstration Programs* [25 U.S.C. §1616p], which authorizes the Secretary, acting through IHS, to fund demonstration programs for IHPs to address chronic shortages of health professionals. The section specifies the purposes of the demonstration programs, and requires that the program incorporate an advisory board composed of representatives from tribes, IHPs, and Indian communities served by the program.

Section 113. Exemption from Payment of Certain Fees

This section adds a new **IHCIA Section 124** *Exemption of Payment of Certain Fees* [25 U.S.C. §1616q], which exempts employees of a THP or UIO from the payment of licensing, registration, and other fees imposed by a federal agency, to the same extent that Public Health Service (PHS) Commissioned Corps officers or other IHS employees are exempt from the fees.

Subtitle B—Health Services

Subtitle B includes sections that amend IHCIA Title II "Health Services" authorizing a number of specific non-behavioral health programs and activities, including prevention activities, diabetes and cancer programs, Indian men's health, Indian school health education programs, research and epidemiological centers, and a fund for the elimination of funding inequities among health care programs. The ACA amends a number of programs in this title. It also authorizes a report that studies and makes recommendations about contract health service (CHS)[25] funding and how IHS funding is distributed across IHS service areas. CHS refers to services that IHS, ITs, or TOs may purchase, through contract, from private providers in instances where the THP cannot provide the needed care.

Section 121. Indian Health Care Improvement Fund

This section amends **IHCIA Section 201** [25 U.S.C. §1621] with new language that authorizes the Secretary, acting through IHS, to use funds designated as the "Indian Health Care Improvement Fund" (IHCIF), to eliminate tribes' deficiencies in health status and resources (as defined in the section), eliminate backlogs in provision of health care to Indians, meet health needs efficiently and equitably, eliminate inequities in funding for both direct care and CHS, and augment the ability of IHS to meet 10 specified health service responsibilities. The Secretary is authorized to expend IHCIF funds either directly or through contracts or compacts under ISDEAA. The section also prohibits using funds appropriated under this section to offset funds appropriated under other laws, permits IHCIF allocation among service units and THPs, and requires the Secretary to determine (in consultation with the affected ITs and TOs) the apportionment of funds among service units, ITs, and TOs for the specified health service responsibilities. The section also requires that THPs be equally eligible for funds with IHS programs and requires that appropriations under this section be included in the base budget of the IHS for subsequent fiscal years. The section requires the Secretary to submit a report to Congress three years after enactment on the current health status and resource deficiencies for each tribe or service unit, and specifies the data to be included in this report. In addition, the section specifies

[25] Beginning with the FY2014 IHS Budget Justification, the contract health service is now referred to as purchased/referred care. See U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

that nothing in the section is intended to diminish the primary responsibility of the IHS to eliminate backlogs in unmet health care or to discourage additional efforts by IHS to achieve parity among tribes.

Section 122. Catastrophic Health Emergency Fund

This section replaces **IHCIA Section 202** [25 U.S.C. §1621a] with new language that establishes the Catastrophic Health Emergency Fund (CHEF), administered by the Secretary through IHS headquarters, to meet extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. The section specifies the uses, administration, and regulations of this fund. It also specifies that CHEF consists of appropriations and third-party reimbursements to which IHS is entitled for treatments paid for by CHEF, and requires that no part of the CHEF or the administration thereof be subject to contract or grant (including those made under ISDEAA). It prohibits CHEF from being apportioned on an Area Office, Service Unit, or any other basis. The section also prohibits funds appropriated to CHEF from being used to offset or limit other IHS appropriations and it requires that all reimbursements to which IHS is entitled from any source, by reason of treatment rendered to any victim of a disaster or catastrophic illness, the cost of which was paid from CHEF, be deposited into CHEF.

Section 123. Diabetes Prevention, Treatment, and Control

This section inserts a new **IHCIA Section 204** *Diabetes Prevention, Treatment, and Control* [25 U.S.C. §1621c], which requires the Secretary, acting through IHS and in consultation with ITs and TOs, to determine the incidence of diabetes and its complications among Indians and, based on the incidence determined, what actions IHS service units need to take to prevent, treat, and control the disease, including effective ongoing monitoring. The Secretary is required—to the extent indicated and with medical consent—to screen Indians for diabetes and for conditions that indicate a high risk for diabetes. The section also permits screening through Internet-based programs, and requires the Secretary to establish a cost-effective approach to ensure ongoing monitoring of diabetes indicators. In addition, the Secretary is required to maintain model diabetes projects in existence at enactment, and is required to provide recurring funding to ITs and THPs for diabetes projects that these entities operate under this section, including funding for projects in existence at enactment and funded thereafter.

In addition, the section authorizes the Secretary to provide dialysis programs for IHS, ITs, and TOs, including equipment and staffing. The Secretary is also required to consult with the ITs and TOs in each IHS area on diabetes programs, establish diabetes patient registries in each IHS Area Office, and ensure that the data collected are disseminated to other Area Offices. The section also authorizes diabetes control officers in each IHS Area Office and states that any activity carried out by a diabetes control officer that is the subject of a contract or compact of ISDEAA, and any funds made available to carry out these activities may not be divisible for the purposes of ISDEAA.

Section 124. Other Authority for Provision of Services and Long-Term Care

This section inserts a new **IHCIA Section 205** [25 U.S.C. §1621d], which authorizes the Secretary to provide funding, through programs and services of IHS, ITs, and TOs, for health-care-related services and programs (not otherwise specified in IHCIA) for hospice care, assisted living, long-term care, and home- and community-based services (as defined in this section). The section also specifies eligibility criteria for long-term care services, authorizes funding through IHS, ITs, and TOs, for "convenient care services" pursuant to IHCIA Section 307(c)(2)(A), and

repeals IHCIA Section 821, which had authorized a demonstration for home-and community based services.

This section also amends **IHCIA Section 822** [25 U.S.C. §1680l] by authorizing the Secretary, acting through the IHS, to provide, directly or through ISDEAA contracts or compacts with THPs, long-term care and health care services associated with long-term care at any long-term care or related facility owned or operated by a THP directly or under ISDEAA. The section requires that the agreements provide for sharing staff and other services between an IHS facility and the contracting IT's or TO's facility. The section authorizes such contracts to allow delegation to the contractors of necessary supervision over IHS employees, and permits ITs and TOs to construct, renovate, or expand nursing facilities. The section also specifies certain terms of the agreement, including funding allocations, and specifies that any nursing facility funded under this section must meet the requirements for such facilities under Medicare statute. The section requires the Secretary to provide necessary technical and other assistance to tribal applicants, and encourages the use of existing underused facilities and permits the use of swing beds, for long-term or similar care.

Section 125 Third Parties Reimbursements

This section amends **IHCIA Section 206** [25 U.S.C. §1621e] by inserting new language that permits the United States, ITs, and TOs the right to recover reasonable charges billed (or, if higher, the highest amount a third party would pay for care and services from a non-governmental provider) for health services provided by these entities to an individual, to the same extent that the individual or any nongovernmental provider of health services would be eligible to receive reimbursement or indemnification. The section specifies that entities from whom recovery can occur include insurance companies, health maintenance organizations, employee benefit plans, third-party tortfeasors, state political subdivisions, local governments, or any other responsible or liable third parties. The section limits the right of recovery against any state to circumstances where the health services are covered under workers' compensation laws or a no-fault automobile accident insurance plan. The section prohibits state or local laws, contract provisions, insurance or health maintenance organization policies, employee benefit plans, self-insurance plans, managed care plans, or other health care plans or programs entered into or renewed after November 23, 1988, from preventing or hindering the right of recovery. The section also prohibits any action by the United States, an IT, or a TO from affecting the right of an injured person to collect for the portion of their damages not covered hereunder. In addition, the section permits the United States, an IT, or a TO to enforce the right of recovery by intervening or joining in specified civil actions or proceedings, or by instituting a separate civil action (after notifying the individual or his representatives or heirs), and requires reasonable efforts to notify the individual. The section also authorizes ITs or TOs, independent of the rights of the injured or diseased person, to recover from tortfeasors or their insurers the reasonable value of health services provided or paid in accordance with the Federal Medical Care Recovery Act.

The section prohibits the United States from recovering from an IT's, TO's, or UIO's self-insurance plan, but allows recovery from a tribe if the tribal governing body provides specific written authorization for a specified time period and permits expenditure of amounts recovered to provide additional health services. The section requires the awarding of reasonable attorney fees and costs of litigation to prevailing plaintiffs under this section, prohibits specified health insurance and related entities from denying reimbursement of an IHS or IT's or TO's claim on the basis of the claim's format (if the format meets certain standards), and applies a specified statute

of limitations.[26] The section applies to UIOs the same rights of recovery, for the populations they serve, as those allowed to ITs and TOs for their served populations. The section also provides that nothing in it limits the right of the United States, an IT, or a TO to recover under any applicable federal, state, or tribal law, including medical lien laws.

Section 126. Crediting of Reimbursements

This section amends **IHCIA Section 207** [25 U.S.C. §1621f] with language that requires that—except as provided under IHCIA Section 202 regarding the CHEF or under IHCIA Section 813 regarding services to ineligible persons—all reimbursements received or recovered for provision of health service by IHS, an IT, a TO, or a UIO are required to be credited to the respective entity (including the service unit providing the health service). The section requires that reimbursements be used as specified under IHCIA Section 401 ("Section 151. Treatment of Payments under SSA Health Benefits Programs"). The section also prohibits IHS from offsetting or limiting the amounts obligated to any service unit, or any entity receiving IHS funding, because of the receipt of reimbursements under this section.

Section 127. Behavioral Health Training and Community Education Programs

This section amends **IHCIA Section 209** [25 U.S.C. §1621h] by inserting new language requiring the HHS Secretary, acting through IHS, and the Secretary of the Interior, in consultation with IT and TOs, to conduct a study and compile a list of specified types of staff positions within the Bureau of Indian Affairs (BIA), IHS, ITs, and TOs, whose qualifications should include training in the identification, prevention, education, referral, or treatment of mental illness, dysfunction, or self-destructive behavior. The appropriate secretary is required to provide culturally relevant training criteria appropriate for each type of position and to ensure that this training has been or will be provided. IHS is also required, upon request by a IT, TO, or UIO, to develop and implement a program of community education on mental illness, or assist the requester with doing so. The section specifies that when the positions are funded under ISDEAA the appropriate secretary is required to ensure that training costs are included in the contract or compact. The section also requires the IHS to provide technical assistance for obtaining and developing community education materials. Within 90 days of enactment, the HHS Secretary is required to develop a plan, to be implemented under the Snyder Act, to increase behavioral health services by at least 500 staff positions within five years, with at least 200 of such positions devoted to child, adolescent, and family services.

Section 128. Cancer Screening

This section amends **IHCIA Section 212** [25 U.S.C. §1621k] by adding that mammography be provided under standards established by the Secretary under the SSA, to ensure the safety and accuracy of the mammography and other cancer screenings.

Section 129. Patient Travel Costs

This section amends **IHCIA Section 213** [25 U.S.C. §1621l] to insert new language that authorizes the Secretary, through IHS, to provide funds for specified patient travel costs associated with receiving IHS-funded health care services (those provided directly by IHS or through ISDEAA contract or compact). These services include emergency air transport and non-emergency air transport where ground transport is not feasible; transportation by ambulance,

[26] 28 U.S.C. § 2415.

specially equipped vehicle, or private vehicle where no other transportation is available; or other means required when air or motor vehicle transport is not available. The section also authorizes the Secretary to provide funding for qualified escorts, as defined in the section.

Section 130. Epidemiology Centers

This section amends **IHCIA Section 214** [25 U.S.C. §1621m] with new language that requires the Secretary to establish an epidemiology center in each IHS Area to carry out seven specified functions, in consultation with ITs, TOs, or UIOs. The section specifies that an epidemiology center is subject to ISDEAA. The section also requires that the Director of the Centers for Disease Control and Prevention (CDC) provide technical assistance to these epidemiology centers. The section also authorizes the Secretary to make grants to ITs, TOs, and UIOs, and eligible intertribal consortia (as defined) to operate an epidemiology center and to conduct epidemiological studies of Indian communities, and specifies the criteria for applicants and the uses of such grants. The section further requires that epidemiology centers operated under such grants be treated as public health authorities for purposes of the Health Insurance Portability and Accountability Act[27] (HIPAA). In addition, the section requires the Secretary to grant such centers access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the Secretary's possession, and specifies that such centers' activities are, for purposes of HIPAA, for research or disease prevention and control.

Section 131. Indian Youth Grant Program

This section amends **IHCIA Section 216(b)(2)** [25 U.S.C. §1621o] by striking reference to Section 209(m) regarding prohibited uses of grant funds and inserts reference to Section 708(c), regarding intermediate adolescent behavioral health services ("Section 708. Indian Youth Program").

Section 132. American Indians into Psychology program

This section amends **IHCIA Section 217** [25 U.S.C. §1621p] by replacing it with new language that authorizes the Secretary, acting through the IHS director, to establish a grant program to award grants of not more than $300,000 to nine colleges and universities for developing and maintaining Indian psychology career recruitment programs. The section requires that one grant be awarded to the University of North Dakota to establish a *Quentin N. Burdick American Indians into Psychology Program*. The section also requires that grants be awarded to locations throughout the United States to maximize their availability to Indian students, including awarding grants to locations that had not previously operated programs. In addition, the section requires the Secretary to issue regulations for competitive funding, and specifies conditions of the grants, including recipients' service obligations. The section authorizes to be appropriated $2.7 million for FY2010 and for each fiscal year thereafter.

Section 133. Projects Related to Communicable and Infectious Diseases

This section strikes **IHCIA Section 218** [25 U.S.C. §1621q] replacing it with new language that authorizes the Secretary to make grants to ITs and TOs for projects to prevent, control, and eliminate communicable and infectious diseases, provide public information and education on such diseases, provide education and skills improvement activities on such diseases for health professionals, and establish demonstration projects for the screening, treatment, and prevention of

[27] P.L. 104-191, act of August 21, 1996, 110 Stat. 1936, as amended.

the hepatitis C virus. Grant recipients are encouraged to coordinate their activities with the CDC and state and local health agencies. The section also authorizes the Secretary to provide technical assistance, upon request, and requires the Secretary to make a biennial report to Congress.

Section 134. Licensing[28]

This section amends **IHCIA Section 221** [25 U.S.C. §1621t] to exempt licensed health care professionals from state licensing requirements while employed by a THP providing services under an ISDEAA contract or compact.

This section also amends **IHCIA Section 106** [25 U.S.C. §1615] to insert new language that authorizes the Secretary to provide programs or allowances to encourage specified health professionals and scholarship and stipend recipients under IHCIA Sections 104 (Indian health professions scholarships), 105 (IHS extern programs), 106 (Community Education Allowances), and 115 (Health Training Programs for Community Colleges) to join or continue in an IHP, and to work in rural or remote areas where significant numbers of Indians reside. These programs or allowances include licensing and board or certification examination assistance that may be used to help individuals to transition into IHPs. The section also authorizes the Secretary to provide technical assistance to these health professionals to assist them with fulfilling their service obligations. The section also authorizes programs and allowances for IHS and tribal health professionals to take leave of their duty stations for a period of time each year for specified continuing professional education.

Section 135. Liability for Payment

This section amends **IHCIA Section 222** [25 U.S.C. §1621u] to exempt a patient who receives IHS-authorized CHS from being held liable for any charges or costs associated with those authorized services. The section also requires the Secretary to notify, within five business days of the provider receiving a claim, the CHS provider and the patient who receives the services that the patient is not liable for the claim. The section prohibits the CHS provider from recourse against the patient for payment if the notice has been received or if the claim has been deemed accepted under IHCIA Section 220(b) (CHS claims that IHS failed to respond to in the allotted time).

Section 136. Offices of Indian Men's Health and Indian Women's Health

This section amends **IHCIA Section 223** [25 U.S.C. §1621v] to insert new language that authorizes the Secretary, acting through IHS, to establish an office within IHS known as the "Office of Indian Men's Health." The section specifies that a director heads the office and coordinates and promotes the health status of Indian men in the United States. The section requires that the Secretary, acting through IHS, submit a report to Congress describing the activities carried out by the director and any findings with respect to the health of Indian men. The section also requires the Secretary, acting through IHS, to establish an "Office of Indian Women's Health" to monitor and improve the quality of Indian women's health of all ages.

Section 137. CHS Administration and Disbursement Formula

This section adds a new **IHCIA Section 226** *Contract Health Service Administration and Disbursement Formula* [25 U.S.C. §1621y], which requires the Government Accountability Office (GAO) to submit a report, as soon as practicable after enactment, to specified

[28] The text below reflects the amendments that ACA Sec. 10221(b)(2) made to this section.

congressional committees and the Secretary, and make it available to each IT, regarding specified elements of the CHS program. Upon receipt of the report, the Secretary is required to consult with ITs regarding the program, including its funding distribution, to determine the adequacy of the current funding formula, and any modifications that are required for the program to be funded at such level as GAO may recommend.[29] The Secretary is authorized, following this consultation, to initiate procedures to negotiate or promulgate regulations to establish a disbursement formula for future CHS program funding.

Subtitle C—Health Facilities

Subtitle C includes sections that amend IHCIA Title III "Health Facilities." This title includes sections related to health care and sanitation facilities. IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities operated by IHS and tribes. IHS also funds the construction of water supply and sewage facilities and solid waste disposal systems, and provides technical assistance for the operation and maintenance of such facilities.

The ACA sets new requirements for the priority system for building and renovating facilities and new requirements for closure of IHS-operated health care facilities. It also authorizes demonstration projects to increase the number of facilities available to provide services to American Indians and Alaska Natives including demonstration projects for funding mobile and modular health facilities—two mechanisms considered to build health facilities more rapidly. As discussed below, IHS maintains a priority system to determine which facilities will be built and in what order. The agency also notes that due to funding constraints some facility construction or renovation projects are completed in phases, which may delay completion and increase costs.[30]

Section 141. Health Care Facilities Priority System

This section amends **IHCIA Section 301** [25 U.S.C. §1631] to require the Secretary, acting through IHS, to maintain a health care facility priority system developed in consultation with ITs and TOs that prioritizes tribal needs, includes the methodology for prioritization, and allows for the nomination of new projects at least once every three years. The priority list may also include the top 10 priority facilities for four specified types of facilities as well as other facilities or needs that IHS may identify. The section requires that the Secretary ensure that the planning, design, construction, renovation, and expansion of facilities operated under ISDEAA are fully and equitably integrated into the health care facility priority system. The section also prohibits a project's priority in effect at enactment from being affected by a new facility priority system if the project meets specified criteria and was identified in the FY2008 IHS budget justification as being in the top 10 for four specified types of facilities.[31]

[29] GAO has released two reports on the Contract Health Service (CHS) program: (1) GAO-11-767, "Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need." See http://www.gao.gov/new.items/d11767.pdf, September 23, 2011; and (2) GAO-12-446, "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program." See http://www.gao.gov/assets/600/591631.pdf, June 15, 2012.

[30] IHS FY2012 Budget Justification.

[31] The four types of facilities are inpatient health care facilities, outpatient health care facilities, staff quarters, and youth regional treatment centers.

The section also defines the Facilities Appropriations Advisory Board and a Facilities Needs Assessment Workgroup,[32] and requires—not later than one year after enactment—the Secretary to submit to specified committees of Congress an initial report with a national ranked list of all IHS, IT, and TO health care facilities needs developed for the board and workgroup, and requires the Secretary to update the report every five years beginning in 2011. The section also requires the Secretary to submit to the President, for inclusion in reports to Congress,[33] an annual report describing the new health care facility priority system and its methodology, and listing top 10 facilities for four specified types of facilities with justifications and projected costs. The Secretary is required to prepare this annual report in consultation with ITs, TOs, and UIOs and is required to review the ITs' and TOs' total unmet facility needs. The section also requires the GAO to study the methodologies used by IHS in developing the health care facility priority system and in making facility needs assessments, and to report to specified committees of Congress and the Secretary. The section further requires the Secretary to consult with ITs and TOs, and confer with UIOs in developing innovative approaches to address unmet facility needs; and makes facility funds appropriated under the Snyder Act subject to ISDEAA.

Section 142. Priority of Certain Projects Protected

This section amends **IHCIA Section 301** [25 U.S.C. §1631] to add a new subsection that prohibits a project's priority in effect at enactment from being affected by a new facility priority system (see "Section 141. Health Care Facilities Priority System" above) if the project was identified in the FY2008 IHS budget justification as being in the top 10 for the four specified types of facilities; had completed both Phase I and Phase II of the construction priority system in effect prior to enactment; or is selected by the Secretary on the Secretary's initiative or pursuant to an IT or TO request.

Section 143. Indian Health Care Delivery Demonstration Project

This section amends **IHCIA Section 307** [25 U.S.C. §1637] by inserting new language that authorizes the Secretary to make grants to, or construction contracts or agreements with, ITs and TOs under ISDEAA to establish demonstration projects to test alternative health care delivery systems through health facilities to Indians, including through construction and renovation of hospitals, health centers, health stations, and other facilities or through cooperative agreements or other arrangements with other health care providers. The section specifies the uses of funds and permits their use to match federal and other funds. The section requires that equal criteria be used in evaluating tribal and IHS facilities, and requires integration of ISDEAA facility planning and construction into demonstration projects. The section defines "convenient care services" as any primary care service that is offered in an alternative setting or outside of regular working hours. The section also authorizes the Secretary to permit demonstration projects meeting certain specified criteria and gives preference to demonstration projects that meet these criteria and are located in the following Service Units: Cass Lake, MN; Mescaleroa, NM; Owyhee and Elko, NV; Schurz, NV; and Ft. Yuma, CA.

In addition, the section requires the Secretary to promulgate regulations for application approval; it also establishes granting criteria, the grant selection process, and the requirements for technical assistance. The section also permits facilities, under the demonstration projects, to provide

[32] The specified workgroup and advisory board existed prior to enactment.

[33] IHCIA Section 801, which was not amended by the ACA, requires the President, each fiscal year to submit a number of required reports to Congress describing various IHCIA-authorized programs and other topics related to Indian health.

services to otherwise ineligible persons—that is, those who are not eligible for IHS services—and extends hospital privileges in IHS facilities to non-IHS health practitioners.

Section 144. Tribal Management of Federally Owned Quarters

This section adds a new **IHCIA Section 309** *Tribal Management of Federally Owned Quarters* [25 U.S.C. §1638a], which authorizes THPs operating a health care facility and the associated federally owned quarters pursuant to an ISDEAA contract or compact to establish reasonable rental rates for the federally owned quarters, by notifying the Secretary, and to collect the rent directly. The section sets the objectives of the THP's rental rates, requires that such quarters remain eligible for improvement and repair funds to the same extent as federally owned quarters, and requires at least 60 days' notice before changes in the rental rate. In addition, the section specifies requirements for direct rent collection by a THP, requires federal employees subject to the rent to pay the THP directly, and sets the effective date for a retrocession of rent collection authority. The provision also permits rental rates in Alaska to be comparable to those in the nearest established community with a year-round population of 1,500.

Section 145. Other Funding for Facilities

This section adds a new **IHCIA Section 311** *Other Funding, Equipment, and Supplies for Facilities* [25 U.S.C. §1638e], which authorizes the head of any federal agency that funds equipment or other supplies used for the planning, design, construction, or operation or a health care or sanitation facility (as defined) to transfer funds, equipment, or supplies to the Secretary. These transfers must be used for the planning, design, or construction of a health care or sanitation facility in accordance with the IHCIA, and with the purposes for which the funds were made available to the transferring agency. The section also authorizes the Secretary to accept such funds and use equipment and supplies for the planning, design, construction, and operation of health care and sanitation facilities for Indians, including facilities operated under ISDEAA contracts or compacts. In addition, the section states that funds received under this section must not affect facility priority established under IHCIA Section 301.

The section also authorizes the Secretary to enter into interagency agreements with federal or state agencies or other entities to accept funds, equipment, or supplies to plan, design, and construct health care or sanitation facilities to be administered by an IHP in order to carry out the purposes of IHCIA or the purposes for which the funds were appropriated or provided. The section requires the Secretary, acting through IHS, to establish, by regulation, standards for the planning design, construction, and operation of health care or sanitation facilities serving Indians under IHCIA; and requires that, notwithstanding other provisions of law, other applicable HHS regulations apply to funds transferred under this section.

Section 146. Modular Component Facilities Demonstration Program

This section adds a new **IHCIA Section 312** *Indian Country Modular Component Facilities Demonstration Program* [25 U.S.C. §1638f], which requires the Secretary, acting through the IHS, to establish a demonstration program to award grants for the establishment of not less than three modular component health care facilities (as defined). Grants will be awarded for the purchase, installation, and maintenance of such facilities in Indian communities for the provision of health care services. The section requires the Secretary to solicit petitions from ITs for modular component health care facilities; establishes petition criteria; and specifies that the Secretary is required to give priority to projects already on the IHS facilities construction priority list and to applications that demonstrate that modular facilities can be constructed more quickly and more

economically than traditional facilities while adequately meeting health care service needs. The section also specifies that entities receiving grants under this section are not eligible for entry on the facilities construction priority list in FY2011 or any successor lists. ITs are eligible for grants under this section regardless of their participation in ISDEAA contracts or compacts. ITs and TOs receiving funds under this section are subject to ISDEAA. This section also requires the Secretary to submit a report, not later than one year after grants are awarded, describing grant activities and potential benefits. Finally, the section authorizes $50 million to be appropriated for the first five fiscal years and such sums as may be necessary in subsequent fiscal years.

Section 147. Mobile Health Stations Demonstration Program

This section adds a new **IHCIA Section 313** *Mobile Health Demonstration Program* [25 U.S.C. §1638g], which requires the Secretary, acting through the IHS, to establish a demonstration project to award funds for uses specified, including providing specialty health care (as defined) to at least three mobile health station projects (as defined by this section). Tribal consortia (as defined) are eligible for grants under this section after submitting a petition to the Secretary with required information. The Secretary is also required to submit a report to Congress, not later than one year after the demonstration has been established, describing and evaluating the demonstration program's activities and benefits. There are authorized to be appropriated $5 million for each of the first five fiscal years and such sums as may be necessary for each fiscal year thereafter to carry out the grant program under this section.

Subtitle D—Access to Health Services

Subtitle D amends IHCIA's Title IV "Access to Health Services," which authorizes IHS health care facilities to receive reimbursements from Social Security Act's (SSA's) Medicare and Medicaid programs. This authorization was a major component of the original IHCIA passed in 1976. The title establishes a "special fund" to receive the reimbursements and specifies what they can be used for. These reimbursements are an important source of funds for IHS. In FY2014, IHS estimated that it will receive approximately $1.1 billion from reimbursements.[34] These reimbursements are used to augment services received at IHS-funded facilities because IHCIA excludes Medicare or Medicaid reimbursements from being considered when determining annual Indian health appropriations. Other non-IHCIA sections of the ACA also make changes to IHS-funded facilities' ability to bill SSA programs and include provisions to increase American Indian and Alaska Native enrollment in these programs. These provisions are described in CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*, by Elayne J. Heisler.

The ACA adds the State Children's Health Insurance Program (CHIP) to the programs that IHS health care facilities may bill, and expands the ability of THPs to bill these programs directly. In addition to amendments related to SSA programs, this subtitle also includes sections related to private insurance and sections related to coordination between IHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD).

Section 151. Treatment of Payments under SSA Health Benefits Programs

This section amends **IHCIA Section 401** [25 U.S.C. §1641] to require that payments received by an IHP or a UIO from Medicare, Medicaid, or CHIP may not be considered in determining appropriations for Indian health care services. The section prohibits the Secretary from providing

[34] U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

services to Indians with coverage under Medicare, Medicaid, or CHIP in preference to those Indians without such coverage. The section also requires that Medicare and Medicaid payments to IHS facilities be placed in a special fund held by the Secretary, and requires the Secretary to ensure that each IHS service unit receives 100% of the reimbursed amounts to which the service unit's facilities are entitled.

The section requires that amounts in the special fund be used by a facility first (to the extent provided in appropriations acts) to improve IHS facilities so they can comply with the applicable conditions and requirements of Medicare or Medicaid; if the reimbursed amounts are in excess of the amount necessary to make such improvements, the facilities are required to use the funds—after consulting with the tribes being served by the service unit—to reduce health resource deficiencies of Indian tribes, including for additional services authorized in IHCIA Section 205 ("Section 124. Other Authority for Provision of Services and Long-Term Care").

In addition, the section excludes THPs electing to receive payments directly from Medicare or Medicaid—called direct billing—from making payments into, or receiving from, the special fund. The section authorizes a THP to elect to directly bill and receive payments from Medicare, Medicaid, CHIP, or other third-party payors. The section requires that payments be used to improve THP facilities so they can comply with the applicable conditions and requirements of Medicare, Medicaid, or CHIP; or that payments be used to provide additional health care services, or to otherwise achieve the objectives in IHCIA Section 3 ("Section 103. Declaration of National Indian Health Policy"). The section also subjects THP direct payments to all auditing requirements applicable to whichever programs it chooses to bill directly and to all auditing requirements applicable to the IHP. The section requires that a THP receiving reimbursements or payments under Medicare, Medicaid, or CHIP provide to IHS a list of each provider enrollment number (or other identifier) under which the THP receives such reimbursements or payments and requires that IHS share this and other necessary information with the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare, Medicaid, and CHIP programs. The section also requires the Secretary, with assistance from CMS, to examine and implement any administrative changes that facilitate direct billing and reimbursement, including agreements with states necessary to provide for direct billing under Medicaid or CHIP. The section also permits participants (i.e., THPs) to withdraw from the program under the same conditions that an IT or TO may retrocede a contracted program under ISDEAA. In addition, the section authorizes the Secretary to terminate a direct billing participant if the Secretary determines that the participant has failed to comply with certain specified requirements, but requires the Secretary to provide notice and an opportunity to correct the noncompliance. The section cross-references specified sections of the SSA relating to the special fund and the direct billing program.

Section 152. Purchasing Health Care Coverage

This section amends **IHCIA Section 402** [25 U.S.C. §1642] to authorize ITs, TOs, or UIOs to use funds made available for health benefits for IHS beneficiaries under SSA programs, the ISDEAA (except for funds under IHCIA Section 402), or other law (except for Section 404) to purchase health benefits coverage. This may include coverage for service within a contract health service delivery area (CHSDA)[35] or any portion of a CHSDA that would have otherwise been provided by CHS; coverage through a tribally owned and operated health care plan, a state or locally authorized or licensed health care plan, a health insurance provider or managed care organization,

[35] In order to be eligible for the CHS program, American Indians and Alaska Natives must be eligible for IHS services and live within a specified geographic area called a contract health service delivery area, or CHSDA.

or a self-insured plan. The section permits that purchased coverage be based on the financial needs of the individual beneficiaries (as determined by the tribe(s) being served) and permits funds to be used to operate a self-insured plan.

Section 153. SSA Health Benefit Programs Outreach and Enrollment Grants

This section amends **IHCIA Section 404** [25 U.S.C. §1644] to require the Secretary to make grants or enter into contracts with ITs and TOs for programs on or near reservations, trust lands, including using electronics and telecommunications, to assist individual Indians to enroll in Medicare, Medicaid, and CHIP, and other health benefit programs, and pay premiums and cost sharing required by the programs.[36] Payment of premiums and cost sharing may be based on need as determined by the IT or TO. The section also requires the Secretary, acting through IHS, to place conditions as deemed necessary on the contracts and grants, including requirements to determine Indian Medicaid, Medicare, and CHIP populations, educate Indians about the programs' benefits, provide transportation, and develop and implement methods to improve Indian participation in the programs. The section also applies the enrollment, premium, and cost-sharing assistance program to UIOs for the populations they serve, and sets requirements for agreements with such organizations. The section also requires the Secretary, acting through CMS, to consult with states, IHS, ITs, TOs, and UIOs on developing and disseminating best practices to facilitate agreements between the states, ITs, TOs, and UIOs regarding enrollment and retention of Indians in Medicare, Medicaid, and CHIP. The section cross references SSA Section 1139 regarding agreements for collecting, preparing, and submitting applications for Medicaid and CHIP. The section also defines the terms "premium" and "cost sharing."

Section 154. Sharing Arrangements with Federal Agencies

This section amends **IHCIA Section 405** [25 U.S.C. §1645] to insert new language that authorizes the Secretary to enter into or expand arrangements for IHS, ITs, and TOs to share medical facilities and services with the VA[37] and the DOD, but requires consultation with affected tribes prior to finalizing an arrangement. The section prohibits the Secretary from taking any action under this section that impairs (1) an Indian's priority access to, or eligibility for, health care services provided through IHS; (2) a veteran's priority access to VA health care services; (3) the quality of IHS health care provided to an Indian; (4) the quality of VA or DOD health care; or (5) an Indian veteran's eligibility to receive VA health care. The section requires reimbursement to the IHS, ITs, or TOs by the VA or DOD where beneficiaries eligible for VA or DOD services receive care from the IHS, ITs, or TOs.[38] The section prohibits construing the section as creating any right of a non-Indian veteran to IHS health services.

Section 155. Eligible Indian Veteran Services

This section adds a new **IHCIA Section 407** *Eligible Indian Veteran Services* [25 U.S.C. §1647], which makes a congressional finding that collaborations between the Secretary and the VA for treatment of Indian veterans at IHS facilities and increased enrollment for VA services by Indian

[36] Section 508 of American Recovery and Reinvestment Act (P.L. 111-5) exempted American Indians and Alaska Natives from premiums and cost-sharing in Medicaid and CHIP. Sec. 2901 of the ACA also includes provisions to facilitate enrollment in Medicaid and CHIP. See description in CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline,* by Evelyne P. Baumrucker et al.

[37] A memorandum of understanding between IHS and the VA was signed on October 1, 2010; see http://www.ihs.gov/announcements/documents/3-OD-11-0006.pdf.

[38] For information on VA reimbursement, see U.S. Department of Veteran's Affairs, "VA and Indian Health Service Announce National Reimbursement Agreement," press release, December 6, 2012.

tribal veterans should both be encouraged to the maximum extent practicable. The section also reaffirms the goals of a 2003 memorandum of understanding between IHS and VA's Veterans Health Administration regarding VA-authorized treatment of eligible Indian veterans at IHS facilities. The section requires the Secretary to provide for payment for veteran-related, VA-authorized treatment under a local memorandum of understanding. The section requires the Secretary to establish guidelines for such payments to the VA, and prohibits use of funds appropriated for IHS facilities, CHS, or contract support costs to make such payments. The section also requires the Secretary to consult with affected tribes in negotiating local memoranda of understanding, and defines "eligible Indian veteran" and "local memorandum of understanding."

Section 156. Nondiscrimination Under Federal Health Care Programs

This section adds a new **IHCIA Section 408** *Nondiscrimination Under Federal Health Care Programs in Qualifications for Reimbursement for Services* [25 U.S.C. §1647a], which requires federal health care programs to accept an entity operated by IHS, an IT, TO, or a UIO, as a provider eligible to receive payment for health care services furnished to an Indian on the same basis as other qualified providers, if the Indian entity meets generally applicable state or other requirements for providers. The section requires that any requirement that providers be licensed or recognized under state or local law be deemed to have been met by such an Indian entity if the entity meets all applicable standards for licensure, regardless of whether it obtains a license. In accordance with Section 221, the section requires that the licensure of health professionals employed at Indian entities not be taken into account when determining if a facility meets licensure standards if the health professional is licensed in another state. The section also prohibits IHS, IT, TOs, and providers at these facilities from receiving payment or reimbursement from a federal health care program if the facility or provider has been excluded for participation in a federal health program or if the facility or provider's state license has been suspended or revoked. The section defines the term "Federal health care program" and cross-references SSA Section 1139 relating to nondiscrimination against providers operated by IHS, an IT, TO, or UIO.

Section 157. Access to Federal Insurance

This section adds a new **IHCIA Section 409** *Access to Federal Insurance* [25 U.S.C. §1647b], which specifies that, notwithstanding the provisions of Title V, the United States Code, an executive order, or an administrative regulation, an IT or TO carrying out programs under ISDEAA or a UIO carrying out programs under IHCIA Title V is entitled to purchase coverage, rights, and benefits for their employees under the Federal Employees Health Benefits Program[39] or the Federal Employees Group Life Insurance program.[40] The section also states that any necessary employee deductions and agency contributions are to be currently deposited in the Employee's Fund applicable to each program.

Section 158. Exception for Excepted Benefits

This section adds a new **IHCIA Section 410** *General Exceptions* [25 U.S.C. §1647c], which directs that the requirements of the previous provisions of IHCIA Title IV of this act may not apply to certain excepted benefits (involving coverage solely for accidents or disability insurance

[39] Under 5 U.S.C. Chapter 89.

[40] Under 5 U.S.C. Chapter 87.

and certain coverage offered as non-coordinated benefits) defined in Section 2791(c) of the Public Health Service Act (PHSA).

Section 159. Navajo Nation Medicaid Agency Feasibility Study

This section adds a new **IHCIA Section 411** *Navajo Nation Medicaid Agency Feasibility Study* [25 U.S.C. §1647d], which requires the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation[41] as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries. The provision requires the Secretary to consider the feasibility of certain options and to report the results of the study to specified committees of Congress not later than three years after enactment.

Subtitle E—Health Services for Urban Indians

Subtitle E amends IHCIA Title V, which includes sections related to UIOs and services for urban Indians. Although IHS provides services primarily to American Indians and Alaska Natives living on or near reservations, more than half of this population resides in urban areas.[42] Programs funded under IHCIA Title V seek to make IHS more accessible and available to urban Indians.

There are 34 Urban Indian Health Programs (UIHPs). UIHPs may serve a wider range of eligible persons than the general IHS health care programs, such as members of terminated or state-recognized tribes and their children and grandchildren. These 34 UIHPs operate at 41 locations, with different programs offering different services, such as ambulatory health care, health promotion and education, immunizations, case management, and behavioral health services.[43] In addition to IHS grants and contracts, UIHPs receive funding from state and private sources, patient fees,[44] Medicaid, Medicare, and other non-IHS federal programs.[45]

The ACA maintains and amends existing IHCIA Title V sections and includes new sections that, for example, create new requirements for the Secretary to confer with UIOs, authorize the use of Community Health Representatives program (see IHCIA Title I, Section 109), and expand access to health information technology (HIT).

Section 161. Facilities Renovation

This section amends **IHCIA Section 509** [25 U.S.C. §1659] to permit funds authorized under this section to be used by UIOs for the construction and expansion of facilities. Previously, funds authorized under this section could only be used to make minor renovations to facilities to meet or maintain the standards of the Joint Commission for Accreditation of Health Care Organizations (JCAHO).[46]

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[41] The Navajo reservation is located in parts of Arizona, Utah, and New Mexico.

[42] See U.S. Department of Health and Human Services, Indian Health Service, "Urban Indian Health Program: Program Overview." At http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp.

[43] IHS FY2012 Budget Justification.

[44] IHS is forbidden to bill or charge Indians (see 25 U.S.C. 1681 and 25 USC 458aaa-14), but IHCIA Title V does not prohibit UIHPs from charging their patients. "Section 197. Tribal Health Program Option for Cost Sharing" described below permits some THPs to charge for services.

[45] U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

[46] JCAHO now goes by the title The Joint Commission (TJC).

Section 162. Treatment of Certain Demonstration Projects

This section amends **IHCIA Section 513** [25 U.S.C. §1660c] to require that the Oklahoma City and Tulsa demonstration projects in Oklahoma (1) be permanent programs within IHS's direct care program; (2) continue to be treated as IHS service units and operating units in the allocation of resources and coordination of care; (3) continue to meet the requirements and definitions of UIOs under this act; and (4) not be subject to ISDEAA.

Section 163. Requirements to Confer with Urban Indian Organizations

This section adds a new **IHCIA Section 514** *Conferring with Urban Indian Organizations* [25 U.S.C. §1660d], which requires the Secretary to ensure that IHS confers or conferences with UIOs to the greatest extent practicable. It defines "confer" and "conference."

This section also amends **IHCIA Section 502** [25 U.S.C. §1652] to require the Secretary, under authority of the Snyder Act, to enter into contracts with or make grants to UIOs to establish in urban centers programs that meet the requirements of IHCIA Title V. In addition, the section requires the Secretary, acting through IHS and subject to IHCIA Section 506, to include within grants and contracts any conditions necessary to effect the purpose of IHCIA Title V.

Section 164. Expanded Program Authority for Urban Indian Organizations

This section adds a new **IHCIA Section 515** *Expanded Program Authority for Urban Indian Organizations* [25 U.S.C. §1660e] to authorize the Secretary, acting through IHS, to establish programs, including grants, for UIOs that are identical to programs established pursuant to IHCIA Section 218 (prevention of communicable diseases), Section 702 (behavioral health prevention and treatment services), and Section 708(g) (youth multidrug abuse program).

Section 165. Community Health Representatives

This section adds a new **IHCIA Section 516** *Community Health Representatives* [25 U.S.C. §1660f], which authorizes the Secretary to contract with or make grants to UIOs for the employment of Indians trained as health service providers through the Community Health Representatives Program under IHCIA Section 109.

Section 166. Use of Federal Government Facilities and Sources of Supply; HIT

This section adds a new **IHCIA Section 517** *Use of Federal Government Facilities and Sources of Supply* [25 U.S.C. §1660g], which authorizes the Secretary to (1) permit UIOs carrying out contracts or grants under this title to use existing HHS facilities and equipment; (2) donate excess IHS or General Services Administration real or personal property to such organizations; and (3) acquire excess or surplus federal government real or personal property for donation to such organizations (subject to a priority for tribes and tribal organizations). The section permits UIOs carrying out contracts or grants under this title to be deemed to be federal executive agencies under Section 201 of the Federal Property and Administrative Services Act of 1949, with access to federal prime vendors, when the organizations are carrying out IHCIA Title V contracts or grants.

This section also adds a new **IHCIA Section 518** *Health Information Technology* [25 U.S.C. §1660h], which authorizes the Secretary to make grants to UIOs under this title for the development, adoption, and implementation of HIT (as defined in PHSA Section 3000, telemedicine services development, and related infrastructure).

Subtitle F—Organizational Improvements

Subtitle F amends IHCIA Title VI. The title established IHS's organizational position as part of the PHS within HHS. The ACA reaffirms IHS's position in the PHS and establishes that the Director of IHS reports directly to the Secretary. The ACA also establishes an Office of Direct Service Tribes within IHS to address the needs of tribes that receive services administered by IHS as opposed to services administered by an IT or a TO under contract or compact (these are called direct service tribes). In addition, the ACA requires a plan for a new area office for tribes located in Nevada. Under the current IHS organization, tribes in Nevada receive services through the Phoenix Area Office.

Section 171. Establishment of the IHS as an Agency of the Public Health Service

This section amends **IHCIA Section 601** [25 U.S.C. §1661]. It maintains IHS's position within the Public Health Service, and maintains language establishing the IHS Director as an official appointed by the President with the advice and consent of the Senate for a four-year term. This section also amends IHCIA Section 601 to state that the IHS Director reports to the Secretary and the incumbent at enactment will remain as Director. The section specifies that the position of the Director reports directly to the Secretary on all policy and budget matters related to Indian health, interacts with assistant secretaries and agency heads on Indian health, and coordinates department activities on Indian health. The section maintains Indian preference for IHS employment.

Section 172. Office of Direct Service Tribes

This section adds a new **IHCIA Section 603** *Office of Direct Service Tribes* [25 U.S.C. §1663], which establishes an Office of Direct Service Tribes within the office of the IHS Director. The section also specifies the responsibilities of the new office, including providing leadership, guidance and support within IHS for direct service tribes, specified consultation responsibilities, and others.

Section 173. Nevada Area Office

This section adds a new **IHCIA Section 604** *Nevada Area Office* [25 U.S.C. §1663a], which requires the Secretary, in a manner consistent with IHS consultation policy, to submit to Congress, within one year of enactment, a plan to create a new Nevada Area Office distinct from the current Phoenix Area Office. If the Secretary fails to submit a plan, then the Secretary is required to withhold operation funds (as defined) from the IHS Office of the Director provided that such withholding does not adversely impact IHS health services. Withheld funds could be restored at the discretion of the Secretary when the plan is submitted.

Subtitle G—Behavioral Health Programs

Subtitle G amends IHCIA Title VII "Behavioral Health Programs," which includes sections that authorize behavioral health care programs. The ACA replaced the existing Title VII with new language that authorizes programs to create a "comprehensive behavioral health prevention and treatment program" providing a "continuum of behavioral health care" (see IHCIA Sections 701 and 703 of Section 181 below). The ACA also creates a new subsection of Title VII that authorizes new programs focused on preventing youth suicide.

Section 181. Behavioral Health Programs

This section replaces IHCIA Title VII with the following new programs:

Subtitle A—General Programs

Section 701. Definitions

This section adds a new **Section 701** *Definitions* [25 U.S.C. §1665], which defines a number of terms used in the title, including "Alcohol-related neurodevelopmental disorders," "dual diagnosis," "FAS or fetal alcohol syndrome," "rehabilitation," and "substance abuse."

Section 702. Behavioral Health Prevention and Treatment Services

This section adds a new **Section 702** *Behavioral Health Prevention and Treatment Service* [25 U.S.C. §1665a]. The section includes the purpose of the title, which includes directing the Secretary, acting through IHS, to develop a comprehensive behavioral health care program that emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. The section also requires the Secretary to encourage ITs, TOs, and UIOs to develop tribal, local, and area-wide plans for Indian behavioral health services that include assessments of specified behavioral problems, the number of Indians affected, the financial and human costs, the existing and necessary resources to prevent and treat such problems, and an estimate of necessary funding. The section requires the Secretary to coordinate with existing national clearinghouses to include such plans and any reports on their outcomes; ensure access to the plans and outcomes by IHS, ITs, TOs, and UIOs; and provide technical assistance in the development of these plans and related standards of care. The section also requires the Secretary to provide, through IHS, and to the extent feasible and funded, a comprehensive continuum of behavioral health care, as well as specified services for Indian children, adults, families, and elders. The section authorizes ITs, TOs, and UIOs to establish community behavioral health plans, requires IHS and BIA cooperation and assistance in developing and implementing such plans, and authorizes grants to ITs and TOs for technical assistance and administrative support for such plans. The section requires the Secretary, through IHS, ITs, TOs, and UIOs, to coordinate behavioral health planning with other federal and state agencies. The section also requires the Secretary, within one year of enactment, to assess the need, availability, and cost for inpatient mental health care and facilities for Indians, including possible conversion of existing, underused IHS hospital beds into psychiatric units.

Section 703. Memoranda of Agreement with the Department of Interior

This section adds a new **IHCIA Section 703** *Memoranda of Agreement with the Department of Interior*[47] [25 U.S.C. §1665b], which requires the Secretary and the Secretary of the Interior, not later than 12 months after enactment, to develop and enter into memoranda of agreement, or update the memoranda of agreement required by Section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act.[48] The section specifies that the memoranda of agreement must address eight specified activities, including a comprehensive assessment and coordination of mental health care needs and services available or unavailable to Indians, and the ensuring and protection of Indians' right of access to general mental health services. The section

[47] HHS and the Department of Interior amended a 2009 memorandum of agreement to incorporate the requirements of the new IHCIA provision. See http://www.ihs.gov/publicinfo/publications/ihsmanual/part3/pt3chapt18/moua.htm.

[48] See Title IV of P.L. 99-570.

further requires that the memoranda include provisions assigning to IHS responsibility for determining the scope of alcohol and substance abuse problems among Indians, assessing existing and needed resources, and estimating necessary funding. The section also requires that each memorandum, renewal, or modification be published in the *Federal Register*, with copies to ITs, TOs, and UIOs.

Section 704. Behavioral Health Prevention and Treatment Program

This section adds a new **Section 704** *Comprehensive Behavioral Health Prevention and Treatment Program* [25 U.S.C. §1665c], which requires the Secretary to provide, through IHS, a program of comprehensive behavioral health, prevention, treatment, and aftercare, for Indian tribal members that includes education, specified treatments, rehabilitation, training, and diagnostic services. The section authorizes the Secretary, through IHS, to provide the services through contracts with public and private behavioral health providers, and requires the Secretary to assist ITs and TOs with developing criteria for certification of providers and accreditation of facilities.

Section 705. Mental Health Technician Program

This section adds a new **Section 705** *Mental Health Technician Program* [25 U.S.C. §1665d], which requires the Secretary, under the Snyder Act, to establish within IHS a mental health technician training and employment program for Indians. The section also requires the Secretary, through IHS, to provide high-standard paraprofessional training in mental health care, to supervise and evaluate these technicians, and to ensure that the program includes using and promoting traditional Indian health care practices of the tribes served.

Section 706. Licensing Requirement for Mental Health Care Workers

This section adds a new **Section 706** *Licensing Requirement for Mental Health Care Workers* [25 U.S.C. §1665e], which, subject to IHCIA Section 221 (regarding licensing), requires that any person employed as a psychologist, social worker, or marriage and family therapist to provide mental health care services to Indians in a clinic be licensed to provide the specified service. The section also provides that a trainee in psychology, social work, or marriage and family therapy may provide mental health care services if the trainee is directly supervised by someone licensed in the specified service, is enrolled in or has completed at least two years of course work in an accredited post-secondary education program for the specified service, and meets other requirements that the Secretary may establish.

Section 707. Indian Women Treatment Programs

This section adds a new **Section 707** *Indian Women Treatment Programs* [25 U.S.C. §1665f], which authorizes the Secretary, consistent with IHCIA Section 701, to make grants to ITs, TOs, and UIOs to develop and implement a comprehensive behavioral health program for prevention, intervention, treatment, and relapse prevention that specifically addresses the cultural, historical, social, and childcare needs of Indian women. The section specifies uses of the grants, including community training and education, counseling, support, and development of prevention and intervention models. The section also requires the Secretary, in consultation with ITs and TOs, to establish grant approval criteria, and to allocate 20% of the program's funds for grants to UIOs.

Section 708. Indian Youth Program

This section adds a new **Section 708** *Indian Youth Program* [25 U.S.C. §1665g], which establishes a number of Indian youth behavioral health programs. The section requires the Secretary, consistent with IHCIA Section 701, to develop and implement a program for acute detoxification and treatment for Indian youth, including behavioral health services, regional treatment centers with detoxification and rehabilitation services, and local programs developed by ITs or TOs under ISDEAA. The section requires the Secretary, through IHS, to construct, renovate, or purchase, and staff and operate (under the Snyder Act) at least one youth regional treatment center or treatment network in each IHS area (treating the California Area as two areas), in a location agreed upon by a majority of the area's tribes; the section also authorizes funding to two specified Alaska Native entities for youth treatment facilities in Alaska.[49] The section authorizes the Secretary to provide intermediate behavioral health services for Indian children and adolescents, and specifies that such services include pretreatment assistance; inpatient, outpatient, and aftercare services; emergency care; suicide prevention; and prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence. The section sets the allowable uses of funds for intermediate behavioral health services, and requires the Secretary, in consultation with ITs and TOs, to develop grant approval criteria.

The section also requires the Secretary, in consultation with ITs and TOs, to identify and use suitable federally owned structures for local residential or regional behavioral health treatment for Indian youths, and establish suitability guidelines. The section allows the use of any such federally owned structure under terms agreed upon by the Secretary, the responsible federal agency, and the IT or TO operating the program. The section also requires the Secretary, ITs, and TOs, in cooperation with the Secretary of Interior, to develop local community-based rehabilitation and aftercare services provided by trained staff in each IHS service unit for Indian youths with significant behavioral health problems, including long-term treatment, community reintegration, and monitoring. The section requires the Secretary, in providing services under this section, to provide for inclusion of family in such services, and specifies that not less than 10% of funds for the local rehabilitation and aftercare services program may be used for outpatient care of adult family members of an Indian youth in the program. The section also requires the Secretary, through IHS, to provide programs and services to prevent and treat multi-drug abuse among Indian youths in Indian communities, on or near reservations, and in urban areas, and provide appropriate mental health services. The section requires the Secretary to collect data on specified aspects of Indian youth mental health for the report under IHCIA Section 801.

Section 709. Mental Health Facilities Design, Construction, and Staffing

This section adds a new **Section 709** *Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing* [25 U.S.C. §1665h], which authorizes the Secretary, through IHS, to provide in each IHS area, not later than one year after enactment, at least one inpatient mental health facility for Indians with behavioral health problems. The section requires that California be considered two areas and requires the Secretary to consider the conversion of existing underused IHS hospital beds into psychiatric units to meet the need for such facilities.

[49] These locations are the Tanana Chiefs Conference, Incorporated and the Southeast Alaska Regional Health Corporation.

Section 710. Training and Community Education

This section adds a new **Section 710** *Training and Community Education* [25 U.S.C. §1665i], which requires the Secretary, in cooperation with the Secretary of the Interior, to develop and implement in each IHS service unit or tribal program a program of community education and involvement for specified tribal community leaders in behavioral health issues, possibly including community-based training, or to assist tribes and tribal organizations in doing so. The section requires the Secretary to provide specified instruction in behavioral health issues to appropriate IHS and BIA employees and personnel in contracted IHS and BIA programs and schools.[50] In addition, this section requires the Secretary, as part of the community education and employee instruction programs, to develop and provide community-based training models addressing specified aspects of behavioral health problems, in consultation with ITs, TOs, and Indian alcohol and substance abuse prevention experts.

Section 711. Behavioral Health Program

This section adds a new **Section 711** *Behavioral Health Program* [25 U.S.C. §1665j], which authorizes the Secretary, through IHS, to develop and implement programs to deliver innovative community-based behavioral health services to Indians, and authorize grants to ITs and TOs for such programs. The section specifies criteria for awarding such grants, and requires the Secretary to use the same criteria in evaluating all project applications.

Section 712. Fetal Alcohol Spectrum Disorder Programs

This section adds a new **Section 712** *Fetal Alcohol Spectrum Disorders Programs* [25 U.S.C. §1665k], which authorizes the Secretary, through IHS, to develop and implement fetal alcohol disorder (FAD) programs (as defined in IHCIA Section 4), consistent with IHCIA Section 701, and to establish criteria for approval of funding applications. The section specifies grant uses, including developing and providing services for the prevention, intervention, treatment, and aftercare for those affected by FAD; early childhood intervention projects; supportive services; and housing. The section requires the Secretary, through IHS, to provide FAD prevention, treatment, and aftercare services as well as specified support services.

The section also requires the Secretary to make grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS to ITs, TOs, and UIOs for applied research projects to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and aftercare for Indians affected by fetal alcohol spectrum disorders. The section requires that 10% of appropriations under this section be used for grants to UIOs funded under IHCIA Title V.

Section 713. Child Sexual Abuse Prevention and Treatment Programs

This section adds a new **Section 713** *Child Sexual Abuse Prevention and Treatment Programs* [25 U.S.C. §1665l], which requires the Secretary, through IHS, and consistent with IHCIA Section 701, to establish in every IHS Area treatment programs for child victims of sexual abuse who are Indians or members of Indian households. The section requires four uses of funding, including developing community education, identifying and providing treatment to victims, and developing culturally sensitive prevention models and diagnostic tools. The section requires that the

[50] The BIA's educational programs were transferred to a new agency, the Bureau of Indian Education (BIE), in 2006.

programs be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act.[51]

Section 714. Domestic and Sexual Violence Prevention and Treatment

This section adds a new **Section 714** *Domestic and Sexual Violence Prevention and Treatment* [25 U.S.C. §1665m], which authorizes the Secretary to establish programs in each IHS Area to prevent and treat Indian victims of domestic violence or sexual violence. The section requires that program funds be used for prevention and community education programs, behavioral health services and medical treatment for victims (including examinations by sexual assault nurse examiners), rape kits, and development of prevention and intervention models (including traditional health care). The section requires the Secretary to establish protocols, policies, procedures, standards, training curricula, and training and certification requirements for victim services within one year of enactment, and requires a report on these activities to specified committees of Congress within 18 months of enactment. The section also requires the Secretary, in coordination with the Attorney General (AG), federal and tribal law enforcement agencies, IHPs, and victim organizations, to develop victim services and victim advocate training programs, for specified purposes, and it requires the Secretary, within two years of enactment, to report to specified committees of Congress on such services and programs, including improvements, obstacles, costs needed to address the obstacles, and any recommendations.

Section 715. Behavioral Health Research

This section adds a new **Section 715** *Behavioral Health Research* [25 U.S.C. §1665n], which requires the Secretary, in consultation with appropriate federal agencies, to make contracts with or grants to ITs, TOs, and UIOs, and appropriate institutions for research on the incidence and prevalence of behavioral health problems among Indians served by IHS, ITs, or TOs and in urban areas. The section directs that research priorities include the multifactorial causes of Indian youth suicide; the interrelationship of behavioral health problems with alcoholism, suicide, homicide, and family violence, especially on children; and the development of models of prevention techniques, especially in regard to children.

Subtitle B—Indian Youth Suicide Services

Section 721. Findings and Purpose

This section adds a new **Section 721** *Findings and Purpose* [25 U.S.C. §1667], which includes the findings and the stated purposes of this section, which are (1) to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth (through specified means); (2) to encourage ITs, TOs, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and (3) to enhance the provision of mental health care services to Indian youth through existing SAMHSA grants.

Section 722. Definitions

This section adds a new **Section 722** *Definitions* [25 U.S.C. §1667a], which defines the following terms: “Administration,” “demonstration project,” and “telemental health.”

[51] P.L. 101-630, Title IV, act of November 28, 1990, 104 Stat. 4544, as amended; 25 U.S.C. § 3202 et seq., 18 U.S.C. §1169.

Section 723. Indian Youth Telemental Health Demonstration Project

This section adds a new **Section 723** *Indian Youth Telemental Health Demonstration Project* [25 U.S.C. §1667b], which authorizes the Secretary to carry out a demonstration project by making four-year grants to not more than five ITs and TOs with telehealth capabilities to use for telemental health services in youth suicide prevention and treatment. The section defines terms and directs the Secretary to give priority to ITs and TOs that serve tribal communities that have a demonstrated need or are isolated and have limited access to mental health services, that enter into collaborative partnerships to provide the services, or that operate a detention facility where youth are detained. The section describes the uses of the grants, including the use of telemedicine for psychotherapy, psychiatric assessments, and diagnostic interviews of Indian youth; the provision of clinical expertise and other medical advice to frontline health care providers working with Indian youth; training and related support for community leaders, family members, and health and education workers who work with Indian youth; the development of culturally relevant educational materials on suicide prevention and intervention; data collection and reporting; and the use of the tribe's traditional health care practices. The section includes requirements for grant applications, encourages collaboration among grantees and grantee reports to the national clearinghouse under IHCIA Section 701, and requires grantees to submit annual reports to the Secretary. In addition, the section requires the Secretary to submit a report to specified committees of Congress no later than 270 days after termination of the demonstration project. The report must include evaluations of whether the project should be made permanent or expanded to more than five grants and to UIOs. The section authorizes appropriations of such sums as may be necessary to carry out this section.

Section 724. SAMHSA Grants

This section adds a new **Section 724** *Substance Abuse and Mental Health Services Administration Grants* [25 U.S.C. §1667c], which requires the Secretary to streamline the process by which ITs and TOs could apply for SAMHSA grants, including providing non-electronic methods. For SAMHSA grants for activities relating to mental health, suicide prevention, or suicide-related risk factors, and for which an IT or TO is eligible, in order to fulfill the trust responsibility of the United States to ITs, the Secretary is required to consider the needs of ITs or TOs that serve populations with documented high suicide rates, regardless of whether those ITs or TOs possess adequate personnel or infrastructure to fulfill all applicable grant requirements. Notwithstanding any other provision of law, no IT or TO is required to apply for SAMHSA grants through a state or state agency. Any state applying for a SAMHSA grant based on statewide data is required to consider the Indian population within the state and make reasonable efforts to collaborate with ITs within the state in implementing SAMHSA grant programs. ITs and TOs are not required to provide non-federal contributions for any SAMHSA grant. The Secretary is also required to conduct outreach to rural and isolated tribes to promote the purposes of this subtitle. The Secretary is required to take other measures to assure access to mental health and suicide prevention services by ITs at high risk, as defined by suicide rates, socioeconomic status, and other factors. The section also authorizes to be appropriated such sums as may be necessary to carry out this section. Finally, the Secretary is required to ensure that any recipient of a grant under PHSA Section 520E (grants for youth suicide prevention and early intervention strategies that are not exclusive to tribal awardees) provides training to those serving Indian youth under the grant program in the recognition of suicide risk among Indian youth.

Section 725 Use of Predoctoral Psychology and Psychiatry Interns

This section adds a new **Section 725** *Use of Predoctoral Psychology and Psychiatry Interns* [25 U.S.C. §1667d], which requires the Secretary to carry out activities to encourage ITs, TOs, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns in order to increase the quantity of patients served by those providers, and for purposes of recruitment and retention.

Section 726. Indian Youth Life Skills Demonstration Program

This section adds a new **Section 726** *Indian Youth Life Skills Development Demonstration Program* [25 U.S.C. §1667e], which authorizes the Secretary, through SAMHSA, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of American Indian and Alaska Native adolescent suicide. The program may use tribal partnerships, assistance from SAMHSA, training, advisory councils, and other approaches. The section also authorizes the Secretary to award demonstration grants to ITs, TOs, or other authorized entities or partnerships who meet specified application requirements, to implement the life skills curriculum. Not more than five grants may be awarded for terms of not less than four years, and at least one grant must be awarded to each of (1) a school operated by the Bureau of Indian Education (BIE); (2) a Tribal school; and (3) a school receiving payments under Section 8002 or 8003 of the Elementary and Secondary Education Act of 1965. Grant funds may be used for a number of specific activities. The Secretary is also required to conduct annual program evaluations, and to report to Congress regarding the program within 180 days of its termination, following a public comment period. The section authorizes an appropriation of $1 million for each of FY2010 through FY2014.[52]

Subtitle H—Miscellaneous

Subtitle H amends IHCIA Title VIII, which includes a number of miscellaneous provisions, including those that require annual reports about activities authorized in IHCIA, and those related to a number of demonstration programs in specified topics and areas. The ACA amends existing sections about certain persons' eligibility for IHS services; adds new sections about medical records; the designation of CHSDAs; IHS budget submissions; monitoring of prescription drugs; required reports; and a variety of other topics.

Section 191. Medical Quality Assurance Records Confidentiality

This section adds a new **IHCIA Section 805** [25 U.S.C. §1675], which makes medical quality assurance records created by an IHP or a UIHP confidential and privileged, and prohibits their disclosure except to specified entities for specified purposes. The section exempts such records from the Freedom of Information Act,[53] requires the Secretary to promulgate regulations, and defines terms.

Section 192. Arizona, North Dakota, and South Dakota as CHSDAs

This section amends **IHCIA Section 808** [25 U.S.C. §1678] with a new section *Arizona as a Contract Health Service Delivery Area* that designates the state of Arizona as an IHS CHSDA for

[52] No funds have been appropriated to support this program.

[53] 5 U.S.C. § 552.

the members of ITs in Arizona. The section also prohibits IHS from curtailing any services as a result of this section.

This section also adds a new **IHCIA Section 808A** *North Dakota and South Dakota as CHSDAs* [25 U.S.C. §1678a], which designates North Dakota and South Dakota as one CHSDA for the purpose of providing CHS to members of ITs in these states. This section also prohibits IHS from curtailing any services as a result of this provision.

This section also amends **IHCIA Section 809** [25 U.S.C. §1679] with a new section *Eligibility of California Indians* that designates specified California Indians as eligible for IHS health services, including members of federally recognized tribes, descendants of Indians residing in California as of June 1, 1852 (if living in California and meeting other criteria), Indians holding trust interests in certain types of land, and Indians (and their descendants) listed on the plans for asset distribution in California under the Act of August 18, 1958 (terminating recognition of certain California tribes). The section prohibits construing anything in the section as expanding California Indians' eligibility for IHS health services beyond their eligibility as of May 1, 1986.

Section 193. Methods to Increase Access to Health Professionals

This section adds a new **IHCIA Section 812** *National Health Service Corps* [25 U.S.C. §1680b], which prohibits the Secretary from removing a member of the National Health Service Corps (NHSC)[54] from an IHP or UIO, or withdrawing funding to support such member, unless the Secretary, acting through the IHS, ensures that Indians will experience no reduction in services. The section also authorizes that, at the IHP's request, the services of NHSC personnel assigned to an IHP may be limited to the persons eligible for services from such program.

Section 194. Health Services for Ineligible Persons

This section amends **IHCIA Section 813** [25 U.S.C. §1680c] with new language that authorizes IHS health services for certain otherwise ineligible persons, including spouses or children of eligible Indians, non-Indian women carrying Indian babies, or persons in need of emergency stabilization, or for prevention of communicable diseases. The section authorizes the governing body of Indian tribes operating health facilities under ISDEAA contracts to determine whether to provide services to ineligible persons. The section also sets criteria for providing services, such as requiring reimbursement and tribal approval, and directs that reimbursements, including under Medicare or Medicaid, be credited to the facility providing the service and be available for expenditure by the facility. The section permits the Secretary to provide services to indigent individuals who are not otherwise eligible for IHS services provided that the state or local government agrees to reimburse IHS for providing this service. The section also permits extending hospital privileges to non-IHS health care practitioners who provide service to certain ineligible persons.

Section 195. Annual Budget Submission

This section adds a new **IHCIA Section 826** *Annual Budget Submission* [25 U.S.C. §1680p], which requires the President, effective with the submission of the FY2011 budget, to request amounts that reflect changes in the cost of health care services as adjusted by the consumer price index for inflation, and amounts that reflect changes in the size of the population served by IHS.

[54] For more information about the National Health Service Corps, see U.S. Department of Health and Human Services, Health Resources and Services Administration, "National Health Service Corps," http://nhsc.hrsa.gov/.

Section 196. Prescription Drug Monitoring

This sections adds a new **IHCIA Section 827** *Prescription Drug Monitoring* [25 U.S.C. §1680q], which requires the Secretary, in coordination with the Secretary of the Interior and AG, to establish a prescription drug monitoring program, to be carried out at facilities operated by IHS, ITs, TOs, and UIOs. The section also requires the Secretary to submit a report within 18 months of enactment to specified congressional committees describing (1) the prescription drug monitoring program needs of facilities operated by IHS, ITs, TOs, and UIOs; (2) the planned development and the means to carry out a prescription drug monitoring program, including relevant statutory or administrative limitations; and (3) the need for coordination with any state prescription drug monitoring program. The section requires the AG, in conjunction with the Secretary and the Secretary of the Interior, to conduct (1) an assessment of the capacity of, and support required by, relevant federal and tribal agencies to collect and analyze data and exchange information regarding incidents of prescription drug abuse in Indian communities and exchange information regarding prescription drug abuse in Indian communities; and (2) training for Indian health care providers, tribal leaders, law enforcement, and school officials regarding awareness and prevention of prescription drug abuse and strategies to improve and address prescription drug abuse in Indian communities. The section also requires the AG, within 18 months of enactment, to submit a report to specified congressional committees that describes certain factors regarding the AG's responsibilities related to prescription drug abuse in Indian communities.[55]

Section 197. Tribal Health Program Option for Cost Sharing

This section adds a new **IHCIA Section 828** *Tribal Health Program Option for Cost Sharing* [25 U.S.C. §1680r], which states that nothing in IHCIA limits the ability of a THP operating any health program, service, function, activity, or facility funded in whole or in part by IHS through a compact with IHS under Title V of the ISDEAA, to charge an Indian for services provided by the THP. The section also states that nothing in IHCIA authorizes IHS to charge an Indian for services or to require a THP to charge an Indian for services.

Section 198. Disease and Injury Prevention Reports

This section adds a new **IHCIA Section 829** *Disease and Injury Prevention* [25 U.S.C. §1680s], which requires the Secretary to submit, within 18 months of enactment, a report to specified congressional committees describing all disease and injury prevention activities conducted by IHS either independently or in conjunction with federal departments, agencies, and ITs, and the effectiveness of such activities.

Section 199. Other GAO Reports

This section adds new **IHCIA Section 830** *Other GAO Reports* [25 U.S.C. §1680t], which requires two specified GAO reports to be submitted to Congress within 18 months of enactment. GAO must conduct studies on (1) the effectiveness of the coordination of health care services provided to Indians: (a) through Medicare, Medicaid, or CHIP; (b) by IHS; or (c) by using funds provided by state or local governments or ITs; and (2) the use of CHS including analyses of amounts reimbursed to providers, suppliers, and entities under CHS, compared to reimbursements through other public and private programs; barriers to access to health care under CHS; adequacy

[55] In October 2011, the Department of Justice released "Indian Health Care Improvement Act, Report Required by 25 U.S.C. 1680q(b)(2)." See http://www.justice.gov/tribal/docs/ihia-pdmp-rpt-to-congress.pdf.

of federal funding of CHS; and other matters GAO determines appropriate. This study must be conducted in consultation with IHS, ITs, and TOs, and must include recommendations on appropriate federal funding for CHS and ways to use such funding efficiently.[56]

Section 200. Traditional Health Care Practices

This section adds a new **IHCIA Section 831** *Traditional Health Care Practices* [25 U.S.C. §1680u], which states that the United States is not liable for damage, injuries, or death that may result from traditional health care practices, consistent with IHS standards for the provision of health care, health promotion, and disease prevention provided pursuant to IHCIA (although the Secretary may promote traditional health care practices). The section further specifies that nothing in the section may be construed to alter any liability of other obligation that the United States has under ISDEAA.

Section 201. Director of HIV/AIDS Prevention and Treatment

This section adds a new **IHCIA Section 832** *Director of HIV/AIDS Prevention and Treatment* [25 U.S.C. §1680v], which requires the Secretary, acting through IHS, to establish within IHS a Director of HIV/AIDS Prevention and Treatment. The Director is required to (1) coordinate and promote HIV/AIDS prevention and treatment activities for Indians; (2) provide technical assistance to ITs, TOs, and UIOs regarding existing HIV/AIDS prevention and treatment programs; and (3) ensure interagency coordination to facilitate the inclusion of Indians in federal HIV/AIDS research and grant opportunities with an emphasis on programs operated under the Ryan White Comprehensive AIDS Resource Emergency Act of 1990[57] and its amendments. The section also requires that, not later than two years after enactment and every two years thereafter, the Director submit to Congress a report describing the activities carried out under this section and the Director's findings related to HIV/AIDS prevention and treatment activities specific to Indians.

Section 10221(b)(3) Abortion Funding Restrictions

This section amends **IHCIA Section 806** [25 U.S.C. §1676] to state that any funds appropriated to HHS may not be used for the performance or coverage of abortion. In addition, the section states that any limitation included in another federal law with respect to the performance or coverage of abortion also applies to funds appropriated to IHS.

Title II—Amendments to Other Acts[58]

Title II of the Indian Health Care Improvement Reauthorization and Extension Act, as enacted, contains one provision that amends and reauthorizes the Native Hawaiian Health Care Act of

[56] GAO has released three reports on the CHS program: (1) GAO-11-767, "Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need." http://www.gao.gov/new.items/d11767.pdf, September 23, 2011; (2) GAO-12-446, "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program," http://www.gao.gov/assets/600/591631.pdf, June 15, 2012; and (3) U.S. Government Accountability Office, *Indian Health Service: Capping Payments for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*, 13-272, April 11, 2013, http://www.gao.gov/products/GAO-13-272.

[57] P.L. 101-381 as amended.

[58] Prior to the mark-up of the IHCIA Reauthorization and Extension Act by the Committee on Indian Affairs, the Act included provisions to amend the SSA. These provisions were either struck during the mark-up or were struck by Sec.

1988 (NHHCA, P.L. 100-579, as amended; 42 U.S.C. §11701-11714), which authorizes health education, health promotion, disease prevention services, and health professions scholarship programs for Native Hawaiians.[59]

Section 202. Reauthorization of Native Hawaiian Health Care Programs

This section reauthorizes expired appropriations authorities in the NHHCA [42 U.S.C. §11701-11714] through FY2019. This section also amends the NHHCA [42 U.S.C. §11705], effective on December 5, 2006, to permit a specified private educational organization (Kamehameha Schools Bishop Estate) identified in Section 7202(16) of the Elementary and Secondary Education Act of 1965 [20 U.S.C.7512(16)] to continue to offer educational programs and services to Native Hawaiians (as defined in that act) first, and to other groups only after the needs of Native Hawaiians have been met. This section also amends the definition of "health promotion" in NHHCA Section 12(2).

10221(b)(4).

[59] This program receives appropriations through the federal health center program. For more information, see http://bphc.hrsa.gov/about/specialpopulations.htm and Appendix A of CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

Appendix A. Timeline of IHCIA Provisions in the ACA

In some instances, the ACA specifies dates for key administrative or programmatic activities or requirements. The following timeline (see **Table A-1**) lists the provisions summarized in this report that include dates, such as those that include dates for reports.

Other activities or requirements that have no date specified in the ACA and are implicitly effective upon enactment (March 23, 2010) are not included in this timeline. All activities authorized in the IHCIA are discretionary and subject to appropriations by Congress. Given this, all deadlines below may not be considered binding since they are subject to appropriated funds. Where available, the timeline includes information on action that IHS, or other federal agencies, have taken in response to deadlines within the two and a half years after enactment (i.e., through September 23, 2012).

Table A-1 lists the ACA dates, which are grouped by subtitle in the IHCIA Reauthorization and Extension Act of 2009. Not all subtitles are included, as some subtitles do not include provisions with specified deadlines. Within each subtitle, table entries are organized with key dates in chronological order. Effective dates stated in terms of days, months, or years after enactment have been converted to calendar dates (e.g., 180 days is 9/19/2010; six months is 9/23/2010, etc.). Table entries for specific implementation requirements or deadlines that are not tied to a specific calendar date are presented at the end of each title. Each table entry includes the IHCIA Reauthorization and Extension Act section number as enacted by Section 10221 of the ACA; a descriptive title for each activity or requirement; a brief description of the activity or requirement; the associated start date, or effective date.[60] All of IHCIA Title VII is amended by Section 181 of the IHCIA Reauthorization and Extension Act; therefore, for requirements contained in Section 181, the subsection of IHCIA Title VII it amends is noted in parentheses.

For additional information on provisions that appear in the timeline, refer to the more detailed section summaries in the report. For definitions of acronyms used in the timeline, refer to **Appendix B**. Unless otherwise stated, references in the table to "the Secretary" refer to the Secretary of Health and Human Services (HHS).

[60] This report does not track actions taken in response to the deadline or effective date; however, this information is available to congressional clients from the author.

Table A-1. Timeline of IHCIA Provisions in the ACA

Section of the IHCIA Reauthorization and Extension Act of 2009 as enacted by ACA Section 10221	Title	Description	Start or Effective Date or Deadline
Subtitle B–Health Services			
Section 127	Behavioral Training and Community Education Programs	Requires the Secretary to develop a plan to increase behavioral health services by creating 500 additional staff positions within 5 years of enactment.	6/21/2010
Section 133	Prevention and Control of Communicable Diseases	Requires the Secretary to submit a biennial report to Congress on the grants awarded for the prevention, control, and elimination of communicable and infectious diseases.	3/23/2012
Section 136	Office of Indian Men's Health	Requires the Secretary, through IHS, to submit a report to Congress describing the activities carried out by the Office of Indian Men's Health and findings related to Indian Men's Health.	3/23/2012
Section 121	Indian Health Care Improvement Fund	Requires the Secretary to submit a report to Congress on the current health status and resource deficiencies of each tribe or service unit.	3/23/2013
Section 137	CHS Administration and Disbursement Formula	Requires GAO to submit a report to Congress describing the results of a study about the CHS program including funding levels and administration of the program.	As soon as practicable after enactment
Subtitle C–Health Facilities			
Section 141	Health Care Facilities Priority System	Requires the Secretary, in the annual report required in Section 801, to submit a report to the President describing the health care facility priority system and the top 10 priorities for various construction projects under this priority system.	February 7, 2011[a]
Section 141	Health Care Facilities Priority System	Requires the Secretary to submit an initial report to Congress with a ranked list of all IHS, IT, and TO health care facility needs. Further requires the Secretary to submit an updated version of this report every 5 years beginning in 2011.	3/23/2011
Section 141	Health Care Facilities Priority System	Requires GAO to study the methodologies used by IHS to develop its health care priority system.	One year after new priority system is developed
Section 147	Mobile Health Station Demonstration Program	Requires the Secretary to submit a report to Congress that describes and evaluates the results of a demonstration project establishing mobile health stations.	One year after the demonstration program is established

Section of the IHCIA Reauthorization and Extension Act of 2009 as enacted by ACA Section 10221	Title	Description	Start or Effective Date or Deadline
Subtitle D–Access to Health Services			
Section 159	Navajo Nation Medicaid Agency Feasibility Study	Requires the Secretary to submit a report to Congress considering the feasibility of considering the Navajo Nation a state for Medicaid purposes.	3/23/2013
Subtitle F–Organizational Improvements			
Section 173	Nevada Area Office	Requires the Secretary to submit a plan to Congress to create a new Nevada Area Office.	3/23/2011
Subtitle G–Behavioral Health Programs			
Section 181 (Section 702)	Behavioral Health Prevention and Treatment Services	Requires the Secretary, acting through IHS, to assess the need, availability, and cost of inpatient mental health care for Indians.	3/23/2011
Section 181 (Section 703)	Memoranda of Agreement with the Department of the Interior	Requires the Secretary, acting through IHS, and the Secretary of the Interior to develop and enter into a memorandum of agreement regarding mental illness and self-destructive behavior among Indians and strategies to address unmet needs.	3/23/2011
Section 181 (Section 714)	Domestic and Sexual Violence Prevention and Treatment	Requires the Secretary to establish protocols, policies, procedures, and programs for victims of domestic or sexual violence.	3/23/2011
Section 181 (Section 714)	Domestic and Sexual Violence Prevention and Treatment	Requires the Secretary to submit a report to Congress on protocols, policies, procedures, and other programs for victims of domestic or sexual violence.	9/23/2011
Section 181 (Section 714)	Domestic and Sexual Violence Prevention and Treatment	Requires the Secretary to submit a report to Congress on domestic and sexual violence prevention and treatment programs. The report should also include improvement needed, obstacles faced, and costs of addressing these obstacles.	3/23/2012
Section 181 (Section 726)	Indian Youth Life Skills Demonstration Program	Requires the Secretary to report on the results of a program evaluation conducted on a demonstration program to test the effectiveness of programs to prevent American Indian and Alaska Native suicide.	180 days after the termination of the demonstration program and after the public comment period.

Section of the IHCIA Reauthorization and Extension Act of 2009 as enacted by ACA Section 10221	Title	Description	Start or Effective Date or Deadline
Subtitle H–Miscellaneous			
Section 195	Annual Budget Submission	Requires the President to include, within the IHS annual budget request and justification, amounts that reflect changes in the cost of health care services adjusted by the consumer price index and amounts adjusted to reflect changes in the IHS service population.	February 1, 2010[b]
Section 196	Prescription Drug Monitoring	Requires the Secretary to submit a report describing the specified elements of the prescription drug monitoring program.	9/23/2011
Section 196	Prescription Drug Monitoring	Requires the AG to submit a report to Congress describing certain factors regarding the AG's responsibility related to prescription drug abuse in Indian communities.	9/23/2011
Section 198	Disease and Injury Prevention Reports	Requires the Secretary to submit a report to Congress describing disease and injury prevention activities by IHS and other federal agencies.	9/23/2011
Section 199	Other GAO Reports	Requires GAO to submit a report to Congress containing the results and recommendations resulting from a study evaluating the effectiveness of the coordination of health care services provided to Indians either through Medicare, Medicaid, or CHIP, with those provided by IHS, with funding from state or local governments or ITs.	9/23/2011
Section 199	Other GAO Reports	Requires the Comptroller General to study (in consultation with IHS, ITs, and TOs), and make recommendations to improve the use of health care services provided under the CHS program, including analyses of amounts reimbursed to providers, suppliers, and entities under CHS, compared to reimbursements through other public and private programs; barriers to access to health care under CHS; and adequacy of federal funding of CHS; and other matters that GAO determines appropriate.	9/23/2011
Section 201	Director of HIV/AIDS Prevention and Treatment	Requires the Director of the IHS office of HIV/AIDS Prevention and Treatment to submit a report to Congress describing the office's activities and findings related to HIV/AIDS prevention and treatment activities specific to Indians.	3/23/2012

Source: Prepared by the Congressional Research Service based on a review of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148).

a. Section 801 requires the President to submit a report to Congress at the time that the budget is submitted. Per 31 U.S.C. Section 1105(a) the President is required to submit his budget to Congress by the first Monday in February of the preceding fiscal year.

b. The FY2011 budget was submitted prior to the ACA's enactment.

Appendix B. Acronyms Used in the Report

ACA	Patient Protection and Affordable Care Act
AG	Attorney General
BIA	Bureau of Indian Affairs
BIE	Bureau of Indian Education
CDC	Centers for Disease Control and Prevention
CHAP	Community Health Aide Program
CHEF	Catastrophic Health Emergency Fund
CHIP	Children's Health Insurance Program
CHS	Contract Health Services
CHSDA	Contract Health Services Delivery Area
CMS	Centers for Medicare and Medicaid Services
DOD	Department of Defense
FAD	Fetal Alcohol Disorder
FAS	Fetal Alcohol Spectrum
GAO	Government Accountability Office
HCERA	Health Care and Education Reconciliation Act
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HUD	Department of Housing and Urban Development
IHCIA	Indian Health Care Improvement Act
IHCIF	Indian Health Care Improvement Fund
IHP	Indian Health Program
IHS	Indian Health Service
IRC	Internal Revenue Code
ISDEAA	Indian Self-Determination and Education Assistance Act
IT	Indian tribe
NHHCA	Native Hawaiian Health Care Act
NHSC	National Health Service Corp
PHS	Public Health Service
PHSA	Public Health Service Act
SSA	Social Security Act
SAMSHA	Substance Abuse and Mental Health Services Administration
THP	Tribal Health Program
TO	Tribal organization
UIHP	urban Indian health project
UIO	urban Indian organization
USC	U.S. Code
VA	Department of Veterans Affairs

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